FORM 170

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 170
Workers' Compensation Trust Fund
Lafayette City Center, 2 Avenue de Lafayette, Boston, MA 02111-1750
Info. Line (800) 323-3249 Inside Mass. / (857) 321-7470 Outside Mass.
www.mass.gov/dia

DIA USE ONLY

AFFIDAVIT OF EMPLOYEE IN APPLICATION FOR TRUST FUND BENEFITS

I, _____, do swear and depose as follows:
(Name of employee/claimant)

1. I reside at _____.

   Home telephone # _____.

2. On the date of my injury my employer was _____.

   The address of my employer is _____.

3. My employer's tel. # is _____. Their email address is _____.

4. My supervisor's name is _____.

5. While working for my employer, I was injured on _____.
(Date of Injury)

   The injury occurred at _____.
(Address, city and town)

   Witnesses to my injury were _____

(Name and address of witness)

_____
(Name and address of witness)

4. I have been informed that my employer, at the time of my injury, did not carry workers' compensation insurance as required by Massachusetts law (M.G.L. c. 152, §25A).

5. I am now applying to the Workers' Compensation Trust Fund (WCTF) for appropriate benefits.

6. At the time of my injury, I was earning wages of $_____ per week from my employer by CASH - CHECK.
(Circle one)

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY
THIS _____ DAY OF_____ 20___
(Date) (Month) (Year)

_____
Signature of Employee/Claimant